EAR • NOSE • THROAT
& Plastic Surgery Specialists

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BOARD CERTIFICATION
Otolaryngology
Facial Plastic Surgery
Sleep Medicine

Throat Irritation Questionnaire

Patient Name _____ Date:_____

Within the past month, how did the following problems affect you? Rank them from 0 (no problem) to 5 (severe problem).

1. Do you experience any problems with your voice or hoarseness?	0	1	2	3	4	5
2. Do you have problems with clearing your throat?	0	1	2	3	4	5
3. Do you have excess throat mucus or post nasal drip?	0	1	2	3	4	5
4. Do you have difficulty swallowing foods, liquids, or pills?	0	1	2	3	4	5
5. Do you have problems coughing after eating or after lying down?	0	1	2	3	4	5
6. Do you experience choking episodes or breathing difficulties?	0	1	2	3	4	5
7. Do you have problems with a troublesome or annoying cough?	0	1	2	3	4	5
8. Do you have sensations of something sticking in your throat or a lump in your throat?	0	1	2	3	4	5
9. Do you have problems with heartburn, chest pain, indigestion, or stomach acid coming up?	0	1	2	3	4	5

Total Score _____

Shared Folder: Patient forms: Throat Irritation Questionnaire